State of Connecticut
Medical Discount Plan (MDP)
License Instructions

Effective January 1, 2006, Public Act 05-237, codified as Connecticut General Statutes §38a-479rr, requires all Medical Discount Plans ("MDP") offering services in the State of Connecticut to be licensed. The State of Connecticut Insurance Department ("Department") is charged with licensing MDPs. If you have any questions about your responsibility to be licensed, please refer to C. G. S. §38a-479rr .

Instructions:

To assure that a MDP license be issued prior to offering services in Connecticut, the Department suggests that applications be submitted at least two months in advance. If your Plan meets the guidelines for licensure, an invoice for the license fee of $500 will be forwarded to you. This invoice must be paid prior to the license effective date.

The application must be filled out, completed, and signed by an officer or authorized representative of the MDP entity certifying that all information provided is true and accurate.

Submit your application and attachments to:

State of Connecticut Insurance Department
Life and Health Division
P O Box 816
Hartford, CT 06142-0816

***Hand delivery or Overnight delivery address ONLY*:**

153 Market Street, 7th floor
Hartford, CT 06103

DO NOT SUBMIT THE LICENSE FEE WITH THIS APPLICATION. You will be billed.

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[ ] NEW **[ ] RENEWAL**

FOR CALENDAR YEAR _____

Name of MDP:_____

List all names (including tradenames, brandnames or dba's) used to market the MDP card:

_____

MDP CT License Number (complete for license renewals only)_____

MDP Tax Identification Number (TIN/FEIN)_____

MDP Business Address:_____

_____

_____

MDP Mailing Address (if different): _____

_____

MDP Phone Number: _____

<u>Contact Information (used by the Department for all future correspondence)</u>:

Name:_____ **Title:**_____

Mailing Address:_____

_____

Phone number:_____ **FAX number:** _____

E-mail address:_____

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Name <u>and description</u> of controlling company or organization: _____
_____
_____

Controlling company's or organization's contact name: _____
_____

Business Address: _____
_____

Mailing Address (if different): _____
_____

Name of related or predecessor controlling company or organization:

_____

Address: _____
_____
_____

Explain current relationship with related or predecessor controlling company:

_____
_____
_____
_____

Has any suspension, sanction or disciplinary action been taken against the MDP in Connecticut or any other state?

[ ] No
[ ] Yes If yes, explain: _____
_____
_____
_____

NOTE: *Failure to disclose actions accurately and truthfully will be cause for denial of your application.*

Has any suspension, sanction or disciplinary action been taken against the controlling company or organization in Connecticut or any other state?

[ ] No
[ ] Yes If yes, explain: _____
_____
_____
_____

NOTE: *Failure to disclose actions accurately and truthfully will be cause for denial of your application.*

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How many total enrollees are served by the MDP: Nationwide:_____in CT:_____

List all Provider Networks with whom MDP has contracts or agreements to provide discounted health care services to Connecticut enrollees:

_____
_____
_____
_____

Indicate types of discount services that the MDP provides to Connecticut enrollees:

[ ] Physician Medical services
[ ] Hospital services
[ ] Laboratory services
[ ] Radiology services
[ ] Prescription Drugs
[ ] Dental Services
[ ] Other – List types of services

_____
_____

Does membership with the MDP's discount card include any insurance coverage?

[ ] No
[ ] Yes If Yes, what are the insurance benefits? And what is the name/s of the insurer/s. Please submit a copy of the policy issued to the MDP and/or its certificateholders._____
_____

Does the MDP and/or its marketing force maintain a Connecticut producer license?

[ ] No
[ ] Yes If Yes, list CT license numbers: _____
_____

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PLEASE SUBMIT THE FOLLOWING AS ATTACHMENTS:

[ ] 1. A copy of the applicant's articles of incorporation, or articles of organization, including all amendments.

[ ] 2. A copy of the applicant's bylaws.

[ ] 3. Certificates from the Secretary of State affirming that the MDP and its controlling company or organization (if applicable) is in good standing in the state. For out of state MDPs, controlling companies or organizations, a certificate that such MDP, controlling company or organization is in good standing in its state of organization.

[ ] 4. A list of the names, addresses, official positions of the individuals who are responsible for conducting the applicant MDP"s affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire ten per cent or more of the voting securities of the applicant. This list shall fully disclose the extent and nature of any contracts or arrangements between the applicant and any individual who is responsible for conducting the applicant's affairs, including any possible conflicts of interest.

[ ] 5. Biographical affidavits on the form provided for <u>each</u> person listed above.

[ ] 6. A statement generally describing the applicant, its personnel and the health care services offered at a discount.

[ ] 7. A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of discount health care services to members. Clearly identify/highlight the language as required by C.G.S. 38a-479rr §2(g) and 38a-479rr §2(h).

[ ] 8. A copy of the form of any contract made or to be made between the applicant and any person for the performance on the applicant's behalf of any function, including, but not limited to, marketing, administration, enrollment, and subcontracting for the provision of health care services to members. This should include internal marketing staff as well as external marketers.

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[ ] 9. A copy of the applicant's most recent financial statements audited by an independent certified public accountant, or, in the case of an applicant that is a subsidiary of a person or parent corporation that prepares audited financial statements reflecting the consolidated operations of the person or parent corporation, a copy of the person's or parent corporation's most recent financial statements audited by an independent certified public accountant , provided the person or parent company also issues a written guarantee that the minimum capital requirements of the applicant required will be met.

[ ] 10. A description of the proposed methods of marketing by the MDP and its brokers/subcontractors.

[ ] 11. A detailed description of the subscriber complaint procedures to be established and maintained.

[ ] 12. The Internet website address of the MPD which includes the up-to-date list of the names and addresses of the providers with which it has contracted. If the website is password protected or for members-only, please provide codes to this Department to review the site.

[ ] 13. Copies of all marketing materials that will be used in Connecticut and a description of the media (TV, internet, mass mailing etc.) used for each of the materials submitted.

[ ] 14. Copies of all the discount cards issued by the MDP.

[ ] 15. Copies of all application forms used to sign up members.

[ ] 16. C. G. S. §38a-479rr § 2(j) requires each MDP to maintain (1) a net worth of at least two hundred fifty thousand dollars, or (2) to post a surety bond in the amount of one hundred thousand dollars. Indicate which option the MDP will use and attach either: a Statement of Net Worth signed by the CFO or CEO, or, a $100,000 bond.

[ ] 17. If you develop or maintain provider networks, please provide a copy of your CT PPN license or Certification that the network does not meet the definition of a PPN (see CT Insurance Department Bulletin/Certification HC-59).

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OFFICER OR AUTHORIZED REPRESENTATIVE CERTIFICATION OF ACCURACY

I, _____, _____of
(Printed Name) (Title)

_____, hereby certify that
(Medical Discount Plan)

I have reviewed the information submitted in accordance with C. G. S. §38a-479rr, and that the information is true and accurate. I understand that at least thirty (30) days advance written notice of any change in the medical discount organization's name, address, principal business address or mailing address must be provided to the Insurance Commissioner. I hereby certify that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

_____ _____
(Signature of Officer or Authorized Representative) (Date)

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____day of _____,

20_____ By _____, and:

□ who is personally known to me, or

□ who produced the following identification: _____

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

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BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. a. Affiant's Full Name (Initials Not Acceptable). _____

   b. Maiden Name (if applicable). _____

2. a. Have you ever had your name changed? _____ If yes, give the reason for the change and provide the full name(s).

   _____

   _____

   b. Other names used at any time (including aliases).

   _____

   _____

3. a. Are you a citizen of the United States?

   b. Are you a citizen of any other country, if so, what country?

4. Affiant's Occupation or Profession. _____

5. Affiant's business address. _____

   Business telephone. _____

6. Education and Training:

College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained

Graduate Studies:	College/ University	City/ State	Dates Attended (MM/YY)	Degree Obtained

Other Training: Name	City/ State	Dates Attended (MM/YY)	Degree/Certification Obtained

(Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information.)

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7. List of memberships in professional societies and associations.

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association

8. Present or proposed position with the applicant entity. _____

_____

9. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years.

Beginning/Ending
Dates (MM/YY)_____ - _____ Employer's Name _____

Address _____City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact ___ _____

Beginning/Ending
Dates (MM/YY)_____ - _____ Employer's Name _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____Offices/Positions Held _____

Supervisor / Contact ___ _____

Beginning/Ending
Dates (MM/YY)_____ - _____ Employer's Name _____

Address _____City _____ State/Province _____

Country _____ Postal Code _____Phone _____Offices/Positions Held _____

Supervisor / Contact ___ _____

10. a. Have you ever been in a position which required a fidelity bond? _____ If any claims were made on the bond, give details. _____

_____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details. _____

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11. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. Attach additional pages if the space provided is insufficient.

_____

Organization/Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known _____

Organization /Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known) _____

12. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

    a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
    _____

    b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
    _____

    c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? _____
    _____

    d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? _____

    e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
    _____

    f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? _____

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g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? _____

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? _____

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? _____

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

If the response to any question above is answered "Yes", please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

13. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

If any of the stock is pledged or hypothecated in any way, give details.

14. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. If the answer is "Yes", please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

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15. Have you ever been adjudged a bankrupt? _____ If yes, provide details _____
_____

16. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity.

    a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? _____

    b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)? _____
    _____

    c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action? _____

    Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

    I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

_____ _____
(Signature of Affiant) Date

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____day of _____, 20_____ By
_____, and:

- ☐ who is personally known to me, or
- ☐ who produced the following identification:_____

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

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BIOGRAPHICAL AFFIDAVIT
Supplemental Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

_____

_____

_____

1. a. Affiant's Full Name (Initials Not Acceptable). _____

   b. Maiden Name (if applicable) _____

2. Affiant's Social Security Number _____

3. Government Identification Number if not a U.S. Citizen _____

4. Foreign Student ID# (if applicable) _____

5. Date of Birth: (MM/DD/YY) _____ Place of Birth: City _____

   State/Province _____ Country _____

6. Name of Affiant's Spouse (indicate 'none' if unmarried) _____

7. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code

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I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

_____ _____

(Signature of Affiant) Date

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ day of _____ , 20_____ By _____, and:

- ☐ who is personally known to me, or
- ☐ who produced the following identification: _____

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

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DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____**[*insert* company name]**("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____**[*insert* company's designated person, position, or department, address and phone]**.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

_____

(Printed Full Name and Residence Address)

_____ _____

(Signature) (Date)

State of_____ County of _____

The foregoing instrument was acknowledged before me this_____day of_____ 20_____ By _____,

and□ _____who is personally known to me, or

□ who produced the following identification: _____

[SEAL]

_____

Notary Public

_____

Printed Notary Name

_____

My Commission Expires

SAMPLE BOND FORM

STATE OF CONNECTICUT
MEDICAL DISCOUNT PLAN (MDP) BOND

KNOW ALL MEN BY THESE PRESENTS

That we, _____ of the
(Name of MDP)

County of_____ State of _____

as Principal, and _____, a surety

company having its principal place of business in _____

County of _____State of _____duly authorized to do business in the State of Connecticut, as Surety, are held and firmly bound unto the member/providers of the MEDICAL DISCOUNT PLAN (MDP) named, as Obligees, in the sum of

_____ dollars ($_____) for the payment of which sum the said Principal and Surety do jointly and severally bind themselves, their heirs, executors, administrators, successors, and assigns, and each and every one of them firmly by these presents.

THE CONDITION OF THIS OBLIGATION IS SUCH THAT WHEREAS, the Principal has made application to the Insurance Commissioner of the State of Connecticut for a license to engage in the business of a Medical Discount Plan (MDP) in accordance with the provisions of Public Act 05-237**,** codified as Connecticut General Statutes §38a-479rr, and any regulation promulgated thereunder. This surety is intended for the sole purpose of meeting the obligation as described in Section 2(j) of C.G.S. §38a-479rr: "Each medical discount Plan organization shall at all times (1) maintain a net worth of at least two hundred fifty thousand dollars, or (2) posted a surety bond in the amount of one hundred thousand dollars."

PROVIDED HOWEVER, that all obligations upon this bond shall cease upon the voluntary or involuntary termination of such license except as to such liability as shall have been accrued thereto.

IN WITNESS WHEREOF, the said Principal and Surety have signed and sealed this instrument this

_____ day of _____ 20_____.

WITNESS

_____ By _____L.S.
(As to Principal) _____L.S.

_____ _____L.S. Corporate Seal
(As to Surety) By _____L.S.